



# Telehealth Services Supplement

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# Telehealth Services Supplement

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## Definitions (TH)

### Audio only

The use of real-time telephonic communication that does not include use of video.

### Distant Site

The distant site is the location of the Provider rendering the covered service via telehealth.

### Originating Site

The originating site is the location of the member at the time the service is rendered, or the site where the asynchronous store-and-forward service originates (i.e., where the data are collected). Examples of originating sites include: medical care facility; Provider's outpatient office; the member's residence or school; or other community location (e.g., place of employment).

### Provider

For purposes of this manual supplement, the term "Provider" refers to the billing provider – either a qualified, licensed practitioner of the healing arts or a facility – who is enrolled with DMAS.

### Remote Patient Monitoring

Remote Patient Monitoring (RPM) involves the collection and transmission of personal health information from a beneficiary in one location to a provider in a different location for the purposes of monitoring and management. This includes monitoring of both patient physiologic and therapeutic data.

### Store-and-Forward

Store-and-forward means the asynchronous transmission of a member's medical information from an originating site to a health care Provider located at a distant site. A member's medical information may include, but is not limited to, video clips, still images, x-rays, laboratory results, audio clips, and text. The information is reviewed at the Distant Site without the patient present with interpretation or results relayed by the distant site Provider via synchronous or asynchronous communications.

## Telehealth

Telehealth means the use of telecommunications and information technology to provide access to medical and behavioral health assessment, diagnosis, intervention, consultation, supervision, and information across distance. Telehealth encompasses telemedicine as well as a broader umbrella of services that includes the use of such technologies as telephones, interactive and secure medical tablets, remote patient monitoring devices, and store-and-forward devices. Telehealth includes services delivered in the dental health setting (i.e., teledentistry), and telehealth policies for dentistry are covered in the dental manuals.

## Telemedicine

Telemedicine is a means of providing services through the use of two-way, real time interactive electronic communication between the member and the Provider located at a site distant from the member. This electronic communication must include, at a minimum, the use of audio and video equipment. Telemedicine does not include an audio-only telephone.

## Virtual Check-In

A Virtual Check-In is a brief patient-initiated asynchronous or synchronous communication and technology-based service intended to be used to decide whether an office visit or other service is needed.

# **Reimbursable Telehealth Services**

Attachment A lists covered services that may be reimbursed when provided via telehealth. Specifically:

## **Table 1 -**

- Table 3 list Telemedicine and Store-and-Forward services
- Table 4 lists Remote Patient Monitoring services
- Table 5 lists Virtual Check-In services
- Table 6 lists audio only services

Services delivered via telehealth will be eligible for reimbursement when all of the following conditions are met:

- The Provider at the distant site deems that the service being provided is clinically appropriate to be delivered via telehealth;
- The service delivered via telehealth meets the procedural definition and components

of the Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, as defined by the American Medical Association (AMA), unless otherwise noted in Table 1 – Table 6 in this Supplement;

- The service provided via telehealth meets all state and federal laws regarding confidentiality of health care information and a patient's right to his or her medical information;
- Services delivered via telehealth meet all applicable state laws, regulations and licensure requirements on the practice of telehealth; and
- DMAS deems the service eligible for delivery via telehealth.

In order to be reimbursed for services using telehealth that are provided to Managed Care Organization (MCO)-enrolled individuals, Providers must follow their respective contract with the MCO. Additional information about the Medicaid MCO programs can be found at <https://www.dmas.virginia.gov/#/cccplus> and <https://www.dmas.virginia.gov/#/med4>.

Additional modality-specific conditions for reimbursement are provided, below.

#### Telemedicine

- Services delivered via telemedicine must be provided with the same standard of care as services provided in person.
- Telemedicine must not be used when in-person services are medically and/or clinically necessary. The distant Provider is responsible for determining that the service meets all requirements and standards of care. Certain types of services that would not be expected to be appropriately delivered via telemedicine include, but are not limited to, those that: are performed in an operating room or while the patient is under anesthesia; require direct visualization or instrumentation of bodily structures; involve sampling of tissue or insertion/removal of medical devices; and/or otherwise require the in-person presence of the patient for any reason.
- If, after initiating a telemedicine visit, the telemedicine modality is found to be medically and/or clinically inappropriate, or otherwise can no longer meet the requirements stipulated in the "Reimbursable Telehealth Services" section, the Provider shall provide or arrange, in a timely manner, an alternative to meet the needs of the individual (e.g., services delivered in-person; services delivered via telemedicine when conditions allow telemedicine to meet requirements stipulated in the "Reimbursable Telehealth Services" section). In this circumstance, the Provider shall be reimbursed only for services successfully delivered.

## Remote Patient Monitoring

- The Provider must have an established relationship with the member receiving the RPM service, including at least one visit in the last 12 months (which can include the date RPM services are initiated).
- The member receiving the RPM service must fall into one of the following five populations, with duration of initial service authorization in parentheses as per below:
  - Medically complex patient under 21 years of age (6 months);
  - Transplant patient (6 months);
  - Post-surgical patient (up to 3 months following the date of surgery);
  - Patient with a chronic health condition who has had two or more hospitalizations or emergency department visits related to such chronic health condition in the previous 12 months (6 months); and/or a
  - High-risk pregnant person (6 months).
- All service authorization criteria outlined in the DMAS Form “DMAS-P268” are met prior to billing the following CPT/HCPCS codes:
  - Physiologic Monitoring: 99453, 99454, 99457, 99458, and 99091
  - Therapeutic Monitoring: 98975, 98976, 98977, 98980, and 98981
  - Self-Measured Blood Pressure: 99473, 99474
- Providers must meet the criteria outlined in the DMAS Form “DMAS-P268” and submit their requests to the DMAS service authorization contractor by direct data entry (DDE) via their provider portal. See Appendix D of the *Physician/Practitioner* manual for details on the current service authorization contractor and accessing the provider portal.
- Service authorization requests must be submitted at least 30 days prior to the scheduled date of initiation of services.
- Reauthorizations will be permitted for select services, as appropriate and as per criteria in the DMAS Form “DMAS-P268”.

## Virtual Check-In

- Services must be patient-initiated.
- Patients must be established with the provider practice.
- Must not be billed if services originated from a related service provided within the previous 7 days or lead to a service or procedure within the next 24 hours or at the soonest available appointment.

# **Reimbursement and Billing for Telehealth Services**

## Telemedicine

Distant site Providers must include the modifier **GT** on claims for services delivered via telemedicine.

Place of Service (POS), the two-digit code placed on claims used to indicate the setting, should reflect the location in which a telehealth service would *have normally been provided*, had interactions occurred in-person. For example, if the member would have come to a private office to receive the service outside of a telehealth modality, a POS 11 would be applied. Providers should **not** use POS 02 on telehealth claims, even though this POS is referred to as “telehealth” for other payers. Place of service codes can be found at [https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place\\_of\\_Service\\_Code\\_Set](https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set).

#### Store-and-Forward

Distant site Providers must include the modifier **GQ**.

Place of Service (POS), the two-digit code placed on claims used to indicate the setting, should reflect the location where the distant site provider is located at the time that the service is rendered.

#### Remote Patient Monitoring

No billing modifier is required on claims for services delivered via RPM.

Devices used to satisfy conditions for CPT 99453 and 99454 must automatically digitally upload patient data (i.e., not self-recorded or reported by patients) and automatically transmit either daily recordings of the beneficiary’s physiologic data OR the device must record daily values and transmit an alert if the beneficiary’s values fall outside predetermined parameters for 16 days in a 30-day period. Devices used to satisfy conditions for CPT 98975, 98976 and 98977 must be used to monitor data for 16 days in a 30-day period. These codes cannot be used for monitoring of parameters for which more specific codes are available (i.e., CPT 93296, 93264, 94760).

Services billed for using CPT 99457, 99458 and 99091 may involve review of data collected in conjunction with codes CPT 99453, 99454, or physiologic data manually captured and submitted by the patient/caregiver for billing providers to review. Services billed for using CPT 98980 and 98981 may involve review of data collected in conjunction with codes 98975, 98976, 98977, or therapeutic data (including self-reported data) manually captured and submitted by the patient/caregiver for billing providers to review.

Time requirements associated with CPT 99457, 99458, 98980, 98981, and 99091 can include time spent furnishing care management services, if not billed for under other reported services, as well as time spent on required direct interactive communication. Interactive communication is defined as real-time synchronous, two-way audio interaction. Time spent on a day when the billing provider reports an E/M service (office or other outpatient services) shall not be included. Time counted toward time requirements of other reported services must also not be counted toward the time requirements of the aforementioned codes.

Only providers eligible to bill CMS Evaluation & Management (E&M) services are eligible to bill for RPM services. Clinical staff members—who work under the supervision of the eligible billing provider and are allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who do not individually report that professional service—are allowed to assist in delivery and satisfaction of appropriate RPM service requirements for 99453, 98975, 99457, 99458, 98980, and 98981, but not 99091.

Codes including the provision of RPM devices (99454, 98976, 98977) shall not be billed if patients supply their own device, or have been separately provided relevant durable medical equipment by DMAS.

Place of Service (POS), the two-digit code placed on claims used to indicate the setting, shall reflect the location in which patients would *normally be evaluated*. For example, if the member would have come to a private office to discuss management of the condition being monitored via RPM, a POS 11 would be applied. Providers should not use POS 02 on telehealth claims, even though this POS is referred to as “telehealth” for other payers. Place of service codes can be found at [https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place\\_of\\_Service\\_Code\\_Set](https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set).

An individual provider must not bill for more than one set of RPM services per patient at any given time.

#### Virtual Check-In

No billing modifier is required on claims for the covered Virtual Check-In codes listed, in Table 5 of Attachment A.



Virtual Check-In services do not require service authorization.

Only physicians and other qualified health care professionals – previously defined by the American Medical Association as being an individual who by education, training, licensure/regulation, and facility privileging (when applicable) performs a professional service within his/her scope of practice and independently reports a professional service – may furnish and bill for Virtual Check-In services.

Place of Service (POS), the two-digit code placed on claims used to indicate the setting, should reflect the location in which patients would have received services had the service occurred in-person and not virtually. For example, if the member would have come to a private office to discuss management of the condition being addressed via virtual check-in, a POS 11 would be applied. Providers should **not** use POS 02 on telehealth claims, even though this POS is referred to as “telehealth” for other payers. Place of service codes can be found at

[https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place\\_of\\_Service\\_Code\\_Set](https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set).

## Originating Site Fee (TH)

### Telemedicine

In the event it is medically necessary for a Provider to be present at the originating site at the time a synchronous telehealth service is delivered, said Provider may bill an originating site fee (via procedure code Q3014) when the following conditions are met:

- The Medicaid member is located at a provider office or other location where services can be received (this does not include the member’s residence);
- The member and distant site Provider are not located in the same location; and
- The Provider (or the Provider’s designee), is affiliated with the provider office or other location where the Medicaid member is located and attends the encounter with the member. The Provider or designee may be present to assist with initiation of the visit but the presence of the Provider or designee in the actual visit shall be determined by a balance of clinical need and member preference or desire for confidentiality.

### All telehealth modalities

Originating site Providers, such as hospitals and nursing homes, submitting

UB-04/CMS-1450 claim forms, must include the appropriate telemedicine revenue code of 0780 (“Telemedicine-General”) or 0789 (“Telemedicine-Other”). The use of these codes is currently not applicable for services administered by Magellan of Virginia.

Telehealth services may be included in a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or Indian Health Center (IHC) scope of practice, as approved by HRSA and the Commonwealth. If approved, these facilities may serve as the Provider or originating site and bill under the encounter rate. The encounter rate methodology for FQHCs and RHCs is described in 12VAC30-80-25; the encounter rate for IHCs (including Tribal clinics) is the All Inclusive Rate set by Indian Health Services.

## **Service Limitations (TH)**

Unless otherwise noted in Attachment A, limitations for services delivered via telehealth are the same as for those delivered in-person.

## **Provider Requirements (TH)**

All coverage requirements for a particular covered service described in the DMAS Provider Manuals apply regardless of whether the service is delivered via telehealth or in-person.

Providers must maintain a practice at a physical location in the Commonwealth or be able to make appropriate referral of patients to a Provider located in the Commonwealth in order to ensure an in-person examination of the patient when required by the standard of care.

Providers must meet state licensure, registration or certification requirements per their regulatory board with the Virginia Department of Health Professions to provide services to Virginia residents via telemedicine. Providers shall contact DMAS Provider Enrollment (888-829-5373) or the Medicaid MCOs for more information.

## **Documentation Requirements (TH)**

Providers delivering services via telehealth must maintain appropriate documentation to substantiate the corresponding technical and professional components of billed CPT or HCPCS codes. Documentation for benefits or services delivered via telehealth should be the same as for a comparable in-person service. The distant site Provider can bill for covered benefits or services delivered via telehealth using the appropriate CPT or HCPCS codes with the corresponding modifier and is responsible for maintaining appropriate supporting documentation. This documentation should be maintained in the patient’s medical record.

When billing for an originating site, the originating site and distant site Providers must maintain documentation at the originating Provider site and the distant Provider site

respectively to substantiate the services provided by each. When the originating site is the member's residence or other location that cannot bill for an originating site fee, this requirement only applies to documentation at the distant site.

Utilization reviews of enrolled Providers are conducted by DMAS, the designated contractor or the Medicaid MCOs. These reviews may be on-site and unannounced or in the form of desk reviews. During each review, a sample of the Provider's Medicaid billing will be selected for review. An expanded review shall be conducted if an excessive number of exceptions or problems are identified. Providers should be aware that findings during a utilization review that support failure to appropriately bill for telemedicine services as defined in this policy manual, including use of the GT/GQ modifier, appropriate POS or accurate procedure codes are subject to retractions.

## **Member Choice and Education (TH)**

Before providing a telehealth service to a member, the Provider shall inform the patient about the use of telehealth and document verbal, electronic or written consent from the patient or legally-authorized representative, for the use of telehealth as an acceptable mode of delivering health care services. This documented consent shall be maintained in the medical record. When obtaining consent, the Provider must provide at least the following information:

- A description of the telehealth service(s);
- That the use of telehealth services is voluntary and that the member may refuse the telehealth service(s) at any time without affecting the right to future care or treatment and without risking the loss or withdrawal of the member's benefits;
- That dissemination, storage, or retention of an identifiable member image or other information from the telehealth service(s) shall comply with federal laws and regulations and Virginia state laws and regulations requiring individual health care data confidentiality;
- That the member has the right to be informed of the parties who will be present at the distant (Provider) site and the originating (member) site during any telemedicine service and has the right to exclude anyone from either site; and
- That the member has the right to object to the videotaping or other recording of a telehealth consultation.

If a Provider, whether at the originating site or distant site, maintains a consent agreement that specifically mentions use of telehealth as an acceptable modality for delivery of services including the information noted above, this shall meet DMAS's required documentation of

patient consent.

## Telehealth Equipment and Technology

Equipment utilized for telemedicine must be of sufficient audio quality and visual clarity as to be functionally equivalent to in-person encounter for professional medical services.

Equipment utilized for Remote Patient Monitoring must meet the Food and Drug Administration (FDA) definition of a medical device as described in section 201(h) of the Federal, Food, Drug and Cosmetic Act.

Providers must be proficient in the operation and use of any telehealth equipment.

Telehealth encounters must be conducted in a confidential manner, and any information sharing must be consistent with applicable federal and state laws and regulations and DMAS policy. Health Information Portability and Accountability Act of 1996 (HIPAA) confidentiality requirements are applicable to telemedicine encounters.

The Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) is responsible for enforcing certain regulations issued under HIPAA. Providers shall follow OCR HIPAA rules with the member, including services provided via telehealth. Providers are responsible for ensuring distant communication technologies meet the requirements of the HIPAA rules.

## Attachment A (TH)

Clinicians shall use their clinical judgment to determine the appropriateness of service delivery via telehealth considering the needs and presentation of each individual.

**Table 1. Medicaid-covered medical services authorized for delivery by telemedicine\***

Service(s)	Telemedicine-specific Service Limitations	Code(s)
Colposcopy		• 57452, 57454, 57455, 57456, 57460, 57461
Fetal Non-Stress Test		• 59025

Service(s)	Telemedicine-specific Service Limitations	Code(s)
Prenatal and Postpartum Visits	<ul style="list-style-type: none"> <li>• Synchronous audio-visual delivery is permissible for the prenatal and postpartum services stipulated in CPT 59400, 59410, 59510 and 59515; delivery services for those codes must be completed in person.</li> <li>• Providers should complete at least one in-person visit per trimester for which they bill prenatal services for the purposes of appropriate evaluation, testing, and assessment of risk.</li> </ul>	<ul style="list-style-type: none"> <li>• 59400, 59410, 59425, 59426, 59430, 59510, 59515</li> </ul>
Radiology and Radiology-related Procedures		<ul style="list-style-type: none"> <li>• 70010-79999 and radiology related procedures as covered by DMAS; GQ modifier if store and forward**</li> </ul>
Obstetric Ultrasound		<ul style="list-style-type: none"> <li>• 76801, 76802, 76805, 76810, 76811-76817</li> </ul>
Echocardiography, Fetal		<ul style="list-style-type: none"> <li>• 76825, 76826</li> </ul>
End Stage Renal Disease		<ul style="list-style-type: none"> <li>• 90951 - 90970</li> </ul>
Remote Fundoscopy		<ul style="list-style-type: none"> <li>• 92250; TC if applicable; GQ modifier if store and forward</li> <li>• 92227, 92228; 26 if applicable; GQ modifier if store and forward</li> </ul>
Speech Language Therapy/Audiology		<ul style="list-style-type: none"> <li>• 92507<sup>†</sup>, 92508<sup>†</sup>, 92521, 92522, 92523, 92524</li> </ul>
Diagnosis, analysis cochlear implant function		<ul style="list-style-type: none"> <li>• 92601-92604, 95974</li> </ul>
Cardiography interpretation and report		<ul style="list-style-type: none"> <li>• 93010</li> </ul>
Echocardiography		<ul style="list-style-type: none"> <li>• 93307, 93308, 93320, 93321, 93325</li> </ul>
Genetic Counseling		<ul style="list-style-type: none"> <li>• 96040</li> </ul>
Maternal Mental Health Screening		<ul style="list-style-type: none"> <li>• 96127, 96160<sup>††</sup>, 96161<sup>††</sup></li> </ul>
Physical therapy / Occupational therapy		<ul style="list-style-type: none"> <li>• 97110<sup>†</sup>, 97112<sup>†</sup>, 97150<sup>†</sup></li> <li>• 97530<sup>†</sup>, 97129<sup>†</sup></li> </ul>
Medical Nutrition Therapy		<ul style="list-style-type: none"> <li>• 97804</li> </ul>
Evaluation & Management (Office/Outpatient)		<ul style="list-style-type: none"> <li>• 99202-99205, 99211-99215; GQ modifier if teledermatology and store and forward</li> </ul>
Evaluation & Management (Hospital)		<ul style="list-style-type: none"> <li>• 99221-99223, 99231-99233; GQ modifier if teledermatology and store and forward</li> </ul>
Evaluation & Management (Nursing facility)		<ul style="list-style-type: none"> <li>• 99304-99306</li> <li>• 99307-99310</li> </ul>
Discharge planning (Nursing facility)		<ul style="list-style-type: none"> <li>• 99315, 993169</li> </ul>
Evaluation & Management (Assisted living facility)		<ul style="list-style-type: none"> <li>• 99334, 99335, 99336</li> </ul>
Respiratory therapy	<ul style="list-style-type: none"> <li>• Must have respiratory equipment set up in home and initial in-person visit by a respiratory therapist or member of the clinical team. Restricted to outpatient respiratory therapy.</li> </ul>	<ul style="list-style-type: none"> <li>• 99503, 94664</li> </ul>
Education for Diabetes, Smoking, Diet		<ul style="list-style-type: none"> <li>• G0108, 97802, 97803</li> </ul>

Service(s)	Telemedicine-specific Service Limitations	Code(s)
Early Intervention	<ul style="list-style-type: none"> <li>• Must have family member/caregiver, service coordinator, or member of the clinical team physically present with member during visit.</li> <li>• Initial assessment (T1023) must be in-person with each assessing member of the clinical team physically present with member, except in cases of documented exceptional circumstances, including to prevent a delay in timely intake, eligibility determination, assessment for service planning, IFSP development/review, or service delivery.</li> <li>• Initial service visit (G* codes) must be in-person with a member of the clinical team physically present with member, except in cases of documented exceptional circumstances, including to prevent a delay in timely intake, eligibility determination, assessment for service planning, IFSP development/review, or service delivery.</li> </ul>	<ul style="list-style-type: none"> <li>• T2022</li> <li>• w/ or w/o U1: T1023, T1024, T1027, G0151, G0152, G0153, G0495</li> </ul>

**Table 2. Medicaid-covered mental health and substance use disorder services authorized for delivery by telemedicine**

Service(s)	Telemedicine-specific Service Limitations	Code(s)
Diagnostic Evaluations		• 90791-90792
Psychotherapy		• 90832, 90834, 90837
Psychotherapy for Crisis		• 90839-90840
Pharmacologic counseling		• 90863
Psychotherapy w/ E&M svc		• 90833, 90836, 90838
Psychoanalysis		• 90845
Family/Couples Psychotherapy		• 90846-90847
Group Psychotherapy		• 90853
Prolonged Service, in office or outpatient setting		• 99354-99357
Psychological testing evaluation		• 96130, 96131
Neuropsychological testing evaluation		• 96132, 96133
Psychological or neuropsychological test administration & scoring		• 96136, 96137, 96138, 96139, 96146
Neurobehavioral Status Exam		• 96116, 96121
Add-on Interactive Complexity		• 90785
Health Behavior Assessment		• 96156
Health Behavior Intervention (Individual, group, family)		<ul style="list-style-type: none"> <li>• 96158-96159</li> <li>• 96164-96165</li> <li>• 96167-96168</li> <li>• 96170-96171</li> </ul>
Evaluation & Management (Outpatient)		• 99202-99205, 99211-99215
Evaluation & Management (Inpatient)		• 99221-99223, 99231-99233
Smoking and tobacco cessation counseling		• 99406-99407

Service(s)	Telemedicine-specific Service Limitations	Code(s)
Alcohol/SA structured screening and brief intervention		• 99408-99409
OTP/OBOT Specific Services		• H0004, H0005, H0014*, G9012
SUD Case Management		• H0006
Mental Health Case Management Services		• H0023
IACCT Initial Assessment		• 90889 HK
IACCT Follow-Up Assessment		• 90889 TS
Mental Health Skill Building		• H0046
Crisis Stabilization		• H2019 (ended 11/30/2021)
Crisis Intervention		• H0036 (ended 11/30/2021)
Mobile Crisis Response	Assessment only (See Appendix G to the Mental Health Services Manual)	• H2011 (effective 12/1/2021)
Community Stabilization	Telemedicine-assisted assessment only (See Appendix G to the Mental Health Services Manual)	• S9482 (effective 12/1/2021)
23 Hour Residential Crisis Stabilization	Psychiatric evaluation only (See Appendix G to the Mental Health Services Manual)	• S9485 (effective 12/1/2021)
Residential Crisis Stabilization	Psychiatric evaluation only (See Appendix G to the Mental Health Services Manual)	• H2018 (effective 12/1/2021)
Assertive Community Treatment		• H0040
Psychosocial Rehabilitation		• H2017
Intensive In-Home Services		• H2012
Therapeutic Day Treatment		• H2016
Behavioral Therapy Program		• H2033 (ended 11/30/2021)
Applied Behavior Analysis (ABA)	97151 and 97152 may be provided through telemedicine for reassessments only.	• 97151-97158 (effective 12/1/2021)
Multisystemic Therapy (MST)		• H2033 (effective 12/1/2021)
Functional Family Therapy (FFT)		• H0036 (effective 12/1/2021)
Foster Care Case Management		• T1016
Peer Recovery Support Services (PRSS)		• H0024, H0025, S9445, T1012
Mental Health Partial Hospitalization Program		• H0035
Mental Health Intensive Outpatient Program		• S9480
SUD Partial Hospitalization Program		• S0201
SUD Intensive Outpatient Program		• H0015

**Table 3. Radiology-Related Procedures for Physician Billing Included under Telehealth Coverage**

Procedure Title (Reduced Length)	CPT Code
Fine needle aspiration; with imaging guidance	10022
Biopsy of breast; percutaneous, needle core, using image guidance	19102
Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device	19103
Preoperative placement of needle localization wire, breast	19290



Image guided placement, metallic localization clip, percutaneous, breast biopsy/aspiration	19295
Arthrocentesis, aspiration, and/or injection; major joint or bursa	20610
Transcatheter occlusion or embolization (eg, for tumor destruction, other)	37204
Hepatotomy; for percutaneous drainage of abscess or cyst, one or two stage	47011
Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance	49083
Electrocardiogram, routine ecg with at least 12 leads; with interpretation	93000
Electrocardiogram, routine ecg with at least 12 leads; interpretation and report only	93010
Echocardiography, transthoracic, real-time with image documentation (2d)	93306
Duplex scan of extremity veins including responses to compression and other	93970
Duplex scan of extremity veins including responses to compression and other	93971
Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, other organs	93975
Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, other organs	93976

**Table 4. Medicaid-covered services authorized for delivery via Remote Patient Monitoring**

<b>Procedure Title (Reduced Length)</b>	<b>Code</b>
Collection & interpretation of physiologic data digitally stored/transmitted 30 min per 30d	99091
Remote monitoring of physiologic parameter(s); set-up and education on use of equipment	99453
Remote monitoring of physiologic parameter(s); device(s) supply & daily recording(s) or programmed alert(s) transmission, each 30 days	99454
Remote physiologic monitoring treatment management services; interactive communication with the patient/caregiver during the month; first 20 minutes	99457
Each additional 20 minutes	99458
Remote therapeutic; initial set-up and patient education on use of equipment	98975
Respiratory system device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission, each 30 days	98976
Musculoskeletal system device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission, each 30 days	98977
Remote therapeutic monitoring treatment management services; interactive communication with the patient or caregiver during the calendar month; first 20 minutes	98980
Each additional 20 minutes	98981
Self-measured blood pressure; patient education/training and device calibration	99473
Self-measured blood pressure; reported 2x daily for 30d w/ clinician review and communication of treatment plan	99474



**Table 5. Virtual Check-In Services**

<b>Service</b>	<b>Code</b>
Virtual check-in, E&M-eligible providers, 5-10 min	G2012
Virtual check-in, non-E&M-eligible providers, 5-10 min	G2251
Virtual check-in, E&M-eligible providers, 11-20 min	G2252
Remote evaluation of recorded video and/or images, E&M-eligible providers	G2010
Remote evaluation of recorded video and/or images, non-E&M-eligible providers	G2250

**Table 6. Audio Only Services\***

<b>Service</b>	<b>Code</b>
Telephone evaluation and management service provided by a physician; 5-10 minutes of medical discussion	99441
Telephone evaluation and management service provided by a physician; 11-20 minutes of medical discussion	99442
Telephone evaluation and management service provided by a physician; 21-30 minutes of medical discussion	99443
Telephone assessment and management service provided by a qualified nonphysician health care professional; 5-10 minutes of medical discussion	98966
Telephone assessment and management service provided by a qualified nonphysician health care professional; 11-20 minutes of medical discussion	98967
Telephone assessment and management service provided by a qualified nonphysician health care professional; 21-30 minutes of medical discussion	98968

\* All fee-for-service claims for audio only codes should be billed directly to DMAS, including those delivered in the context of mental health and substance use disorder services. See Chapter V of the Physician/Practitioner Manual for detailed billing instructions.